Progressive Chiropractic Wellness Center
3118 N Sheffield, Suite 1S Chicago, IL 60657 tel:773-525-9355 www.progressivechiropractic.com

PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms. _____
Last Legal First Middle Initial

Name you prefer to be called (nickname): _____ Social Security #: _____

Phone #:( ) _____ Fax #:( ) _____ Cell #:( ) _____

E-mail: _____ Driver's License #: _____

Address: _____ City: _____ State: ___ Zip: _____

Age: _____ Birth Date: _____ Gender: _____ Patient's Employer: _____

Work Address: _____ City: _____ State: ___ Zip: _____

Phone #: ( ) _____ Ext: _____ Occupation: _____

Please circle: single/married/domestic partners/divorced/other: _____ Spouse/partner's name: _____

Note: *Fill out this section only if insured is different than patient.* Name of Insured: _____

Relationship to insured: (please circle one): spouse/domestic partner child other: _____

Address: _____ City: _____ State: ___ Zip: _____

Social Security #: _____ Phone #:( ) _____ Birth Date: _____

Insured's Employer (if different from patient): _____ Phone #:( ) _____

Work Address: _____ City: _____ State: ___ Zip: _____

PERSONAL HEALTH HISTORY

Have you ever been to a chiropractor before? No/Yes, what for? _____

Who referred you to our practice? Person: _____ Advertisement: _____

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What do you hope to do better or enjoy more when you regain your health? _____

When was your last physical exam? _____ Results: _____

Date, and results, if known, of any recent tests: cholesterol: _____ other: _____

Please list all current medications, vitamin/mineral supplements, herbs, including dosage: _____

List any known allergies: _____

If you smoke or have ever smoked, describe how much, and for how long: _____

Describe your recreational drug use: _____ typical alcohol intake (#of drinks per day/per week): _____

Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): _____

Please list and describe all significant previous surgeries: _____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session: _____

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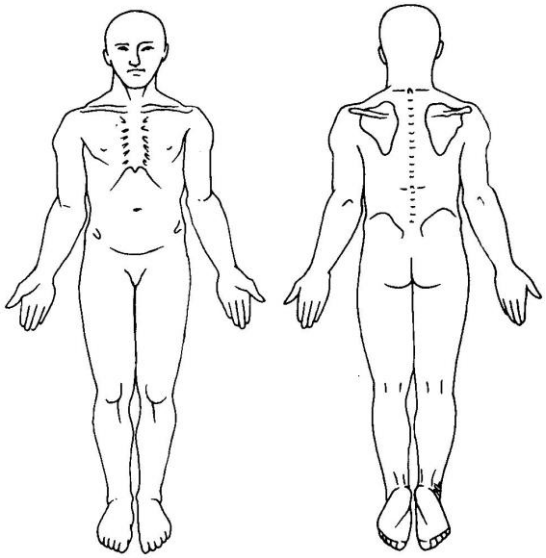
CHIEF COMPLAINT

Name: _____ **Date:**_____ Condition #:_____(use separate form for each condition)

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury *someone else might be legally liable for*? Yes**/**No **Please Initial:**_____ If yes, please fill out accident-specific form at the front desk
2. Please describe the nature of your condition at this time:_____
3. When did your condition first begin? Year:_____Month:_____Day/Date:_____Time:_____
4. Cause of condition (circle all that apply): auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/gradual other explain:_____
5. Have you had anything like this before? No/Yes: when?:_____
6. How often does the problem re-occur?:_____
7. Is the pain (circle): constant, on & off, usually lasting: ___minutes ___hours _____days ___weeks other:_____
8. Lately, has the pain been(circle): getting better getting worse staying about the same
9. Does the pain radiate?, to where:_____
10. What makes it feel better?_____
11. What makes it feel worse?_____
12. If you have seen another professional for this problem, or done any self-care, describe the type of treatment *and* results:___
13. At what time of day, week, or setting (home, recreation, work) is your pain worst?_____
14. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse?
15. What else would you like the Dr. to know about you and/or your condition:_____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY

Please list any significant health problems of parents, grandparents, or siblings:_____

REVIEW OF SYSTEMS

Please write a **number** in the spaces below**: 1.**presently have **2.**previously had **3.**related to accident

GENERAL

_____Frequent or recurring Chills
_____Epilepsy/Convulsions/Seizure
_____Frequent or recurring Dizziness
_____Frequent or recurring Fainting
_____Frequent or recurring Fatigue
_____Frequent or recurring Fever
_____Headache
_____Frequent or recurring Sleep loss
_____Recent Weight Change
_____Anxiety/Panic Attacks
_____Depression
_____Frequent or recurring Sweats
_____Frequent/recurring hives/rashes
_____Frequent/recurring colds/flu
_____Vertigo
_____Fainting
_____Fears/Phobias

GENITO-URINARY/ENDOCRINE

_____Bedwetting
_____Frequent urination
_____Urinary tract infections
_____Painful urination
_____Painful menstruation
_____Prostate trouble
_____Loss of bowel/bladder control
_____Gall Stones
_____Blood in urine
_____Thyroid problems/Goiter
_____Kidney stones
_____Irregular menstrual cycle
_____Hot flashes
_____Diabetes
_____Pelvic Inflam. Dis.
_____Infertility/Miscarriage

RESPIRATORY

_____Spitting up phlegm
_____Chest pain
_____Spitting up blood
_____Difficult breathing
_____Asthma
_____Wheezing
_____Chronic cough
_____Allergies

GASTROINTESTINAL

_____Bloating, belching, gas
_____Esophageal reflux
_____Constipation
_____Frequent heartburn
_____Ulcer
_____Digestive Problems
_____Parasites
_____Pain over stomach
_____Diarrhea
_____Vomiting
_____Nausea
_____Poor appetite
_____Candida/Yeast
_____Hernia

CARDIOVASCULAR

_____Hardening of arteries
_____High blood pressure
_____Pain over heart
_____Bad circulation/ankle swell
_____Rapid heart beat
_____Heart Disease
_____Palpitation/Ireg heart beat
_____Cold Hands &/or Feet

EYES, EARS, NOSE, THROAT

_____Frequent/recurring sore throat
_____Deafness
_____Dental problems
_____Ear problems/Infections
_____Sinus problems
_____Frequent/recurring nose bleeds
_____Vision problems
_____Canker sores
_____Cold sores

OTHER

_____Mononucleosis
_____Psoriasis
_____Sexually Transmitted Disease
_____Whooping Cough
_____Ingrown Toenails/Hang-nails

MUSCULOSKELETAL – pain, numbness, weakness in:

_____Low Back
_____Neck
_____Upper Back
_____Mid Back
_____Between Shoulder Blades
_____Shoulder Blade: R/L both
_____Shoulder: R/L both
_____Foot: R/L bunions/corns
_____Fibromyalgia
_____Arm: R/L both
_____Elbow: R/L both
_____Hand: R/L both
_____Leg: R/L both
_____Hip: R/L both
_____Knee: R/L both
_____Ankle: R/L both
_____Spinal curvature
_____Arthritis/Gout

OTHER

_____Genital Herpes
_____Pnuemonia
_____Sexual Abuse
_____Worms
_____Teeth Problems/Cavities
_____Mumps
_____Root Canal/gumdisease
_____Stroke
_____Shingles
_____Penile/Vaginal Discharge

OTHER

_____Absesses
_____Acne
_____Alcohol/Drug Addiction
_____Anemia
_____Athlete'sFoot/Fungal infection
_____Cancer
_____Chicken Pox
_____Eczema
_____Genital Warts
_____Warts
_____Hepatitis
_____Scarlet Fever
_____HIV
_____Chicken Pox
_____Dry/Cracked heels

OPTIONAL SECTION: NUTRITION

Height:_____ Present Weight:_____ Weight one year ago:_____ Preferred Weight:_____

Please indicate which you eat on a typical day: { }Breakfast { }Lunch { }Dinner # of snacks/day:_____

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

_____Eggs
_____Cheese
_____Skim Milk
_____1% Milk
_____2%Milk
_____Whole Milk
_____Yogurt
_____Other:____

_____Red Meat
_____Pork
_____Fish
_____Ham
_____Beans
_____Chicken/Turkey
_____Tofu/Soy
_____Sausage/Lunch Meats

_____Fruits
_____Vegetables
_____Desserts
_____Grains,Rice,Pasta,Cereal,Bread
_____Butter
_____Margarine
_____Nuts/Seeds/Peanut Butter
_____Other:_____

Fats/Oils:
_____Canola _____Corn
_____Olive _____Peanut
_____Safflower _____Sunflower
_____Other:_____
_____Other:_____
_____Bacon/Hot Dogs, etc.
_____Spicy Foods

Please indicate the estimated # of servings (6-8 oz. cups) of each of the following, which you drink on a typical day:

_____Caffeinated Coffee
_____Decaffeinated Coffee
_____Regular Tea

_____Regular Soft Drinks
_____Diet Soft Drinks
_____Herbal Tea

_____Water
_____Fruit Juices
_____Sports Drinks (i.e.,Gatorade)

_____Other:_____
_____Other:_____
_____Other:_____

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet:_____

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: _____

Was your special diet prescribed by a physician or nutritionist? Yes No _____

Do you have success in following your special diet? Yes No explain:_____